



General Assembly

January Session, 2013

Raised Bill No. 861

LCO No. 2858



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

***AN ACT CONCERNING THE MODERNIZATION OF CERTAIN
MEDICAL FORMS.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-591c of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2013*):

3 (a) (1) Each health carrier shall contract with (A) health care
4 professionals to administer such health carrier's utilization review
5 program and oversee utilization review determinations, and (B) with
6 clinical peers to evaluate the clinical appropriateness of an adverse
7 determination.

8 (2) Each utilization review program shall use current, documented
9 clinical review criteria that are based on sound clinical evidence and
10 are evaluated periodically by the health carrier's organizational
11 mechanism specified in subparagraph (F) of subdivision (2) of
12 subsection (c) of section 38a-591b to assure such program's ongoing
13 effectiveness. A health carrier may develop its own clinical review
14 criteria or it may purchase or license clinical review criteria from

15 qualified vendors approved by the commissioner. Each health carrier
16 shall make its clinical review criteria available electronically to health
17 care professionals with which such carrier has contracted to provide
18 health care services to its covered persons and upon request to
19 authorized government agencies.

20 (b) Each health carrier shall:

21 (1) Have procedures in place to ensure that the health care
22 professionals administering such health carrier's utilization review
23 program are applying the clinical review criteria consistently in
24 utilization review determinations;

25 (2) Have data systems sufficient to support utilization review
26 program activities and to generate management reports to enable the
27 health carrier to monitor and manage health care services effectively;

28 (3) Provide covered persons and participating providers with access
29 to its utilization review staff through a toll-free telephone number or
30 any other free calling option or by electronic means;

31 (4) Coordinate the utilization review program with other medical
32 management activity conducted by the health carrier, such as quality
33 assurance, credentialing, contracting with health care professionals,
34 data reporting, grievance procedures, processes for assessing member
35 satisfaction and risk management; and

36 (5) Routinely assess the effectiveness and efficiency of its utilization
37 review program.

38 (c) If a health carrier delegates any utilization review activities to a
39 utilization review company, the health carrier shall maintain adequate
40 oversight, which shall include (1) a written description of the
41 utilization review company's activities and responsibilities, including
42 such company's reporting requirements, (2) evidence of the health
43 carrier's formal approval of the utilization review company program,

44 and (3) a process by which the health carrier shall evaluate the
45 utilization review company's performance.

46 (d) When conducting utilization review, the health carrier shall (1)
47 collect only the information necessary, including pertinent clinical
48 information, to make the utilization review or benefit determination,
49 and (2) ensure that such review is conducted in a manner to ensure the
50 independence and impartiality of the individual or individuals
51 involved in making the utilization review or benefit determination. No
52 health carrier shall make decisions regarding the hiring, compensation,
53 termination, promotion or other similar matters of such individual or
54 individuals based on the likelihood that the individual or individuals
55 will support the denial of benefits.

56 (e) (1) Not later than January 1, 2014, the commissioner shall
57 develop uniform prior authorization forms for health care services,
58 including, but not limited to, health care professional office visits,
59 prescription drug benefits, and imaging and other diagnostic or
60 laboratory testing. The commissioner shall seek input from health
61 carriers, utilization review companies, health care professionals and
62 other stakeholders for the development of such forms. The
63 commissioner may develop different forms for different health care
64 services as the commissioner deems necessary or appropriate.

65 (2) Any such forms shall (A) not exceed two pages, (B) be available
66 in paper format and electronic format, (C) be capable of being
67 completed and submitted electronically, and (D) be consistent with
68 existing prior authorization forms established by the Centers for
69 Medicare and Medicaid Services and with any national standards
70 pertaining to electronic prior authorization procedures.

71 (3) Upon developing such forms, the commissioner shall notify
72 health carriers of the availability of such forms. Each health carrier
73 shall notify and make such forms available to utilization review
74 companies to which such carrier has delegated any utilization review

75 activities and to health care professionals with which such carrier has
76 contracted to provide health care services to its covered persons. Not
77 later than one hundred eighty days after the commissioner provides
78 such notification, each such health care professional shall use, and each
79 health carrier or utilization review company that requires prior
80 authorization for a health care service shall use and accept, such forms.
81 If such carrier or company fails to accept a prior authorization form
82 developed pursuant to this subsection, for which all required
83 information is submitted, or such carrier or company fails to grant or
84 deny such prior authorization within two hours of such carrier or
85 company's receipt of such prior authorization request, such prior
86 authorization shall be deemed granted.

87 (4) Nothing in this subsection shall prohibit a health carrier or
88 utilization review company from using, in lieu of paper format, a prior
89 authorization system that utilizes an Internet web site, an Internet-
90 based portal or other electronic systems to access or submit a prior
91 authorization form developed pursuant to this subsection.

92 Sec. 2. Section 38a-478e of the general statutes is repealed and the
93 following is substituted in lieu thereof (*Effective October 1, 2013*):

94 (a) Each managed care organization shall, prior to implementing
95 new medical protocols or substantially or materially altering existing
96 medical protocols, obtain input from physicians actively practicing in
97 Connecticut and practicing in the relevant specialty areas. The
98 managed care organization shall also seek input from physicians who
99 are not employees of or consultants, other than to the extent a person is
100 an employee or consultant solely for the purposes of this subsection, to
101 the managed care organization provided the input is not unreasonably
102 withheld. The managed care organization shall obtain the input in a
103 manner permitting verification by the commissioner and shall
104 document the process by which it obtained the input. For the purpose
105 of this section, "medical protocols" shall include, but not be limited to,
106 drug formularies or lists of covered drugs and clinical criteria used for

107 utilization review, as defined in section 38a-591a.

108 (b) Each managed care organization shall (1) make available [, upon
109 the request of a] to its participating [provider] providers on such
110 organization's Internet web site, its current medical protocols, [for
111 examination during regular business hours at the principal
112 Connecticut headquarters of the managed care organization,] and (2) if
113 a managed care organization denies a treatment, service or procedure,
114 the organization shall furnish, upon the request of a participating
115 provider, a copy of the relevant medical protocol to the participating
116 provider, along with an explanation of the denial at the time the denial
117 is made.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2013</i>	38a-591c
Sec. 2	<i>October 1, 2013</i>	38a-478e

Statement of Purpose:

To require the Insurance Commissioner to develop, health care professionals to use, and health carriers to use and accept, uniform prior authorization forms, and to require health carriers and managed care organizations to make available electronically to health care professionals clinical criteria used for utilization review.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]